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## Variability of SCCmec in the Zurich area

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**Abstract** A periodic survey of methicillin-resistant *Staphylococcus aureus* (MRSA) in Zurich in 2004 and 2006 revealed a consistently low prevalence of MRSA. SCCmec and *ccr* typing showed fluctuations in the proportions of SCCmec types and in the carriage of mobile virulence determinants. Together with the presence of variant SCCmecs these findings suggest a high clonal diversity and level of SCCmec recombination. The prevalence of a local “drug clone”, associated with low-level methicillin resistance and rapid growth, significantly decreased. This clone had spread among intravenous drug users, steadily increasing from 1994 to 2001 and was dominant in 2001. Apparently, changes in the management of the Zurich drug scene have restricted the spread of this clone.

### Introduction

Methicillin-resistant *Staphylococcus aureus* (MRSA) were first reported only one year after introduction of the penicillinase-resistant antibiotic methicillin into clinical use and have since become an increasing worldwide problem [12]. Initially, MRSA were restricted to hospitals and sites of high antibiotic use, where they accumulated additional resistances and became multiresistant to all

commonly used antibiotics. Recently, however, nonmulti-resistant MRSA clones with lower oxacillin resistance levels, but apparently higher virulence, have emerged and begun spreading within the community and into hospitals [2, 5, 17, 18].

Methicillin resistance is based on the acquisition of an additional penicillin-binding protein (PBP), PBP2a, which has a lower affinity for  $\beta$ -lactams than the cells' own PBPs. Staphylococci differ in their ability to accept PBP2a for unknown reasons [13]. The restriction of MRSA to specific genetic backgrounds is also reflected by the observation that MRSA have generally evolved separately and sometimes even repeatedly into only five of the main 11 distinct epidemic susceptible *S. aureus* lineages [22]. Methicillin resistance thus depends on both the production of PBP2a and on the genetic composition of the core genome. Strain-specific resistance levels are therefore dictated by the host strain's genetic background and can vary extensively from extremely low (<1  $\mu$ g/ml) to very high (>1000  $\mu$ g/ml) oxacillin minimum inhibitory concentrations (MICs) [1].

The *mecA* gene, coding for PBP2a, is localized on the staphylococcal chromosomal cassette SCCmec, a unique genomic island, which integrates into the staphylococcal genome [8]. The *mecA* gene and its cognate regulatory elements *mecI-mecR1* form the *mec* complex. In some strains the regulatory genes *mecI-mecR1* may be truncated by insertion elements, giving rise to different *mec* complex loci. The other feature common to all SCCmec elements is the *ccr* locus, which encodes recombinases responsible for the site-specific integration and excision of SCCmec [9]. While the *ccr* genes from different SCCmec elements show sequence polymorphisms, the *mecA* gene is highly conserved. SCCmec elements vary to a great extent in size, due to additional resistance determinants, plasmids, transposons, IS elements, and genes unrelated to resistance. The

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classification of *SCCmec* elements is based on the allotype of the *mec* and *ccr* complex as well as the presence of selected loci unrelated to methicillin resistance [19], which has led to the identification of six major *SCCmec* types [10, 11, 14]. A new nomenclature has been proposed to accommodate novel and divergent *SCCmec* types [3]. The older, hospital-associated *SCCmec* types I, II, and III are generally larger due to the accumulation of unrelated resistance determinants and other extraneous DNA into the *SCCmec* element. The emerging community MRSA, with smaller *SCCmec* elements of type IV, V, or VI, are generally only oligoresistant, express lower methicillin resistance, and grow faster, which appears to give them a fitness advantage. Interestingly, the smaller *SCCmec* types have entered more diverse strain lineages than the larger types [21, 23], possibly due to increased mobility, or to a lower fitness burden associated with their typically lower/heterogeneous methicillin resistance.

The convergence of methicillin resistance with virulence is a dangerous development, especially if combined in rapidly growing strains. Examples include the acquisition of the arginine catabolic mobile element (ACME) associated with *SCCmec* [6], or the phage transmitted *pvl* genes [24] that are connected to many community-acquired MRSA (CA-MRSA). A particularly successful clone is strain USA300, which is spreading at a tremendous rate in the United States [15].

In recent years the prevalence of MRSA in the 920-bed University Hospital in Zurich had remained relatively low at approximately 3–6%. An epidemiological study performed in 2003 showed that about 30% of the MRSA isolates collected had low oxacillin MICs (43% had MIC  $\leq$  6  $\mu$ g/ml) [20]. The majority belonged to a local MRSA clone spreading among intravenous drug users in the Zurich area. This particular “drug clone” appeared in 1994 and steadily proliferated, culminating in 2001 and remaining at quite a high level until 2004 when it constituted over 25% of all MRSA isolated [20]. The drug clone carries the novel *SCCmec*<sub>N1</sub> element, containing a *mecB* complex and the *dfrA* and *fusB1* genes coding for trimethoprim and fusidic acid resistance, respectively. It also contains two almost identical *ccrAB4*-like complexes that are similar to previously described *ccrAB4* complexes, and a core genome belonging to the successful Berlin CC45 clone [7, 20]. The very low level methicillin resistance of the drug clone is paired with extremely rapid growth; therefore, we were concerned that this clone may spread beyond its confined circle and acquire additional resistance determinants or virulence factors over time. To follow its fate 56 consecutive, non-duplicate MRSA isolates collected from April to December 2004 (referred to as 2004), mainly from the University Hospital in Zurich, and 55 isolates from June 2006 to February 2007 (referred to as 2006) were analysed.

## Materials and methods

### Polymerase chain reaction (PCR)

Specific primers were used to amplify *pvl* (PVL *lukS* fwd 5'-GTAAAATGTCTGGACATGATCCA-3', PVL *lukF* rev 5'-CAACTGTATTGGATAGCAAAAGC-3'), *tst* (TSST up 5'-CCCTGTTCCCTTATTATCTA-3', TSST down 5'-TTCCTTCGCTAGTATGTTGG-3'), and *arcA* (*arcA*+ 5'-GAGCCAGAAGTACGCGAG-3', *arcA*- 5'-CACGTAACTTGCTAGAACGAG-3').

### Susceptibility testing

Resistance levels for ciprofloxacin, chloramphenicol, trimethoprim, gentamicin, tetracycline, rifampin, fusidic acid, and the MLS antibiotics clindamycin and erythromycin were determined by disk diffusion according to CLSI [4], and oxacillin MICs were obtained by Etest (AB-Biodisk).

### *SCCmec* typing

Isolates were typed according to Oliveira et al. [19]. *ccr* typing was performed as described previously [7, 20].

### Pulsed-field gel electrophoresis

Strains were genotyped by pulsed-field gel electrophoresis of *Sma*I-digested chromosomal DNA, following the protocol given in [20].

### Spa typing

*spa* sequence typing was performed using the Ridom StaphType *spa*-sequencing protocol ([http://www.ridom.de/doc/Ridom\\_spa\\_sequencing.pdf](http://www.ridom.de/doc/Ridom_spa_sequencing.pdf)) and the Ridom SpaServer to identify repeats and assign *spa* types (<http://spaserver2.ridom.de/index.shtml>).

## Results and discussion

MRSA isolates were characterised and grouped according to their *SCCmec* typing profile and their *ccr* type. Antibiotic resistance levels to ciprofloxacin, chloramphenicol, trimethoprim, gentamicin, tetracycline, rifampin, fusidic acid, and MLS antibiotics were measured and oxacillin MICs were determined. Isolates were also screened for the presence of *pvl*, *tst*, and *arcA* by PCR. Unexpectedly, a rather large proportion of MRSA from the second collection period seemed to be unstable and 12 strains lost the *mecA* gene during storage at  $-80^{\circ}\text{C}$ . Eleven of these strains appeared to have lost their entire *SCCmec* elements, as they

**Table 1** Characteristics of the analysed MRSA isolates grouped according to their SCCmec types

Strain	SCCmec	ccr	MIC <sup>a</sup> [μg/ml] Ox	Resistance phenotype									Virulence determinants <sup>b</sup>			Year
				Ci	Cm	Gm	Tc	Ra	Tr	Fa	Cl	Er	tst	pvl	arcA	
ZH 123	I	AB1	12	S	S	S	S	S	S	R	S	R	+			2004
ZH 129	I	AB1	12	S	S	S	S	S	S	R	S	R	+			
ZH 138	I	AB1	>256	R	S	R	S	S	S	S	R	R				
ZH 141	I	AB1	>256	R	I	R	S	S	S	S	R	R				
ZH 261	I	AB1	>256	R	S	R	S	S	S	S	R	R				2006
ZH 276	I	AB1	>256	R	R	R	S	S	S	S	R	R				
ZH 317	I	AB1	>256	R	I	R	I	S	S	S	R	R				
ZH 150	II	AB2	192	R	S	S	S	S	S	S	R	R				2004
ZH 104	II	AB2	256	R	S	S	S	S	S	S	S	R				
ZH 111	II	AB2	256	R	I	S	S	S	S	S	R	R				
ZH 149	II	AB2	256	R	S	S	S	S	S	S	R	R				
ZH 151	II	AB2	256	R	S	S	S	S	S	S	S	R				
ZH 281	II	AB2	0.25	S	S	S	R	S	R	S	S	S				2006
ZH 286	II	AB2	1	R	I	S	S	S	S	S	R	R				
ZH 297	II	AB2	24	R	S	S	S	S	S	S	S	S				
ZH 309	II	AB2	192	R	S	S	S	S	S	S	R	R				
ZH 270	II	AB2	256	R	S	S	S	S	S	S	R	R				
ZH 278	II	AB2	256	R	S	S	S	S	S	S	R	R				
ZH 284	II	AB2	256	R	I	S	I	S	S	S	R	R				
ZH 295	II	AB2	256	R	S	S	S	S	S	S	R	R				
ZH 316	II	AB2	256	R	I	I	R	S	S	S	R	R				
ZH 135	III	AB3 & C	>256	R	S	R	R	S	R	S	S	R				2004
ZH 139	III	AB3 & C	>256	R	R	R	R	R	R	R	S	R				
ZH 146	III	AB3 & C	>256	R	R	R	R	I	R	R	S	R				
ZH 148	III	AB3 & C	>256	R	R	R	R	R	R	R	S	R				
ZH 153	III	AB3 & C	>256	R	R	R	R	I	R	R	S	R				
ZH 162	III	AB3 & C	>256	R	R	R	R	R	R	R	S	R				
ZH 163	III	AB3 & C	>256	R	R	R	R	I	R	R	S	R				
ZH 264	III	AB3 & C	>256	R	S	R	R	R	R	I	R	R				2006
ZH 265	III	AB3 & C	>256	R	S	R	R	R	R	S	R	R				
ZH 115	IV	AB2	1	S	S	S	I	S	S	S	S	R				2004
ZH 116	IV	AB2	1	S	S	S	I	S	S	S	S	R				
ZH 118	IV	AB2	1	S	S	S	R	S	S	S	S	R				
ZH 113	IV	AB2	1.5	S	I	S	R	S	S	S	S	R				
ZH 117	IV	AB2	1.5	S	S	S	R	S	S	S	S	R				
ZH 120	IV	AB2	2	S	S	S	S	S	S	R	I	R				
ZH 108	IV	AB2	3	S	S	S	R	S	S	S	S	R				
ZH 131	IV	AB2	4	I	S	S	R	S	S	R	S	S				
ZH 155	IV	AB2	4	I	S	S	S	S	S	S	S	S				
ZH 130	IV	AB2	16	I	S	S	S	S	S	S	S	S		+		
ZH 158	IV	AB2	48	S	S	S	S	S	S	R	I	R				
ZH 110	IV	AB2	64	S	S	S	S	S	S	S	S	S		+		
ZH 119	IV	AB2	96	S	S	S	R	S	S	S	S	R				
ZH 114	IV	AB2	128	S	S	S	R	S	S	S	S	I			+	
ZH 124	IV	AB2	256	R	S	S	R	S	S	S	R	R		+	+	
ZH 121	IV	AB2	>256	R	S	S	S	S	S	S	S	S				
ZH 136	IV	AB2	>256	R	S	S	S	S	S	S	R	R				
ZH 154	IV	AB2	>256	R	S	S	I	S	S	S	S	S				

**Table 1** (continued)

Strain	SCCmec	ccr	MIC <sup>a</sup>	Resistance phenotype										Virulence determinants <sup>b</sup>			Year
			[μg/ml]														
			Ox	Ci	Cm	Gm	Tc	Ra	Tr	Fa	Cl	Er	tst	pvl	arcA		
ZH 313	IV	AB2	1.5	S	S	S	S	S	S	S	S	S		+		2006	
ZH 282	IV	AB2	3	S	S	S	S	S	S	S	S	S					
ZH 268	IV	AB2	6	S	I	S	S	S	S	S	S	S					
ZH 314	IV	AB2	24	I	I	S	R	S	I	R	S	S		+			
ZH 304	IV	AB2	64	S	I	I	S	S	S	S	S	I					
ZH 285	IV	AB2	128	S	S	S	S	S	S	S	S	S					
ZH 263	IV	AB2	256	R	S	S	S	S	S	S	S	R					
ZH 271	IV	AB2	256	R	S	S	S	S	S	S	S	R		+	+		
ZH 312	IV	AB2	256	R	S	S	R	S	S	S	I	R		+			
ZH 262	IV	AB2	>256	R	S	S	R	S	S	I	S	R					
ZH 266	IV	AB2	>256	S	S	S	S	S	R	S	S	R					
ZH 272	IV	AB2	>256	R	S	S	S	S	S	S	S	R					
ZH 274	IV	AB2	>256	I	S	S	S	S	S	S	S	R					
ZH 275	IV	AB2	>256	S	S	S	S	S	S	S	S	S					
ZH 279	IV	AB2	>256	R	S	S	S	S	S	S	S	R					
ZH 283	IV	AB2	>256	R	S	S	S	S	S	S	S	R					
ZH 291	IV	AB2	>256	R	S	S	S	S	S	R	S	R		+			
ZH 294	IV	AB2	>256	R	S	S	S	S	S	I	S	R					
ZH 310	IV	AB2	>256	R	S	S	S	S	S	I	S	S					
ZH 137	N1	AB4	1.5	R	S	S	S	S	R	R	S	S				2004	
ZH 144	N1	AB4	1.5	R	I	S	I	S	R	R	S	S					
ZH 145	N1	AB4	1.5	R	I	I	S	S	R	R	S	S					
ZH 161	N1	AB4	1.5	R	S	I	S	S	R	R	S	S					
ZH 122	N1	AB4	2	R	S	S	S	S	R	R	S	S					
ZH 126	N1	AB4	2	R	S	S	S	S	R	R	S	S					
ZH 127	N1	AB4	2	R	S	S	S	S	R	R	S	S					
ZH 103	N1	AB4	3	R	S	S	S	S	R	R	S	S					
ZH 105	N1	AB4	3	R	S	S	S	S	R	R	S	S					
ZH 109	N1	AB4	3	S	S	S	S	S	R	R	S	S					
ZH 125	N1	AB4	3	R	S	S	S	S	R	R	S	S					
ZH 147	N1	AB4	3	R	S	S	S	S	R	R	S	S					
ZH 107	N1	AB4	4	S	S	S	S	S	R	R	S	S					
ZH 128	N1	AB4	4	R	S	S	S	S	R	R	S	S					
ZH 132	N1	AB4	4	S	S	S	S	S	R	R	S	S					
ZH 106	N1	AB4	6	S	S	S	S	S	R	R	S	S					
ZH 112	N1	AB4	6	R	S	S	S	S	R	R	S	S					
ZH 277	N1	AB4	1.5	R	I	S	S	S	R	R	S	S					2006
ZH 287	N1	AB4	1.5	R	S	S	S	S	R	R	S	S					
ZH 292	N1	AB4	2	S	S	S	S	S	R	R	S	S					
ZH 315	N1	AB4	3	S	S	S	S	S	R	R	S	S					
ZH 273	VI	AB4	>256	R	S	S	R	R	R	R	R	R				2006	
SCCmec variants																	
ZH 159	I	AB2	192	S	R	S	R	S	S	S	S	S				2004	
ZH 152	II-VAR	AB1 & AB4	1	R	S	S	S	S	S	R	S	S				2004	
ZH 134	II	AB1	48	R	S	R	R	R	R	S	R	R	+				
ZH 133	I/II-VAR	AB1	>256	R	S	R	R	R	S	S	R	R					
ZH 299	II	AB2 & AB1	0.75	S	S	S	S	S	S	S	S	S		+		2006	
ZH 293	II-VAR	AB2 & AB4	6	I	S	S	S	S	S	S	S	S	+				

**Table 1** (continued)

Strain	SCCmec	ccr	MIC <sup>a</sup> [μg/ml] Ox	Resistance phenotype									Virulence determinants <sup>b</sup>			Year
				Ci	Cm	Gm	Tc	Ra	Tr	Fa	Cl	Er	tst	pvl	arcA	
ZH 143	III-VAR	C	3	S	S	R	S	S	S	S	S	S		+		2004
ZH 269	III-VAR	C	6	S	S	R	S	S	R	S	S	S				2006
ZH 298	IV	AB1	0.38	S	S	S	S	S	S	R	S	S				2006
ZH 305	IV	AB2 & AB4	3	S	R	S	R	S	R	R	S	I				

MRSA methicillin-resistant *Staphylococcus aureus*, Ci ciprofloxacin, Cm chloramphenicol, Gm gentamicin, Tc tetracycline, Ra rifampin, Tr trimethoprim, Fa fusidic acid, Cl clindamycin, Er erythromycin

<sup>a</sup>MIC minimal inhibitory concentration determined for Ox (oxacillin)

<sup>b</sup>tst encodes toxic shock syndrome toxin, pvl encodes Pantone-Valentine leukocidin, ArcA belongs to the arginine deiminase pathway gene cluster located on the ACME element

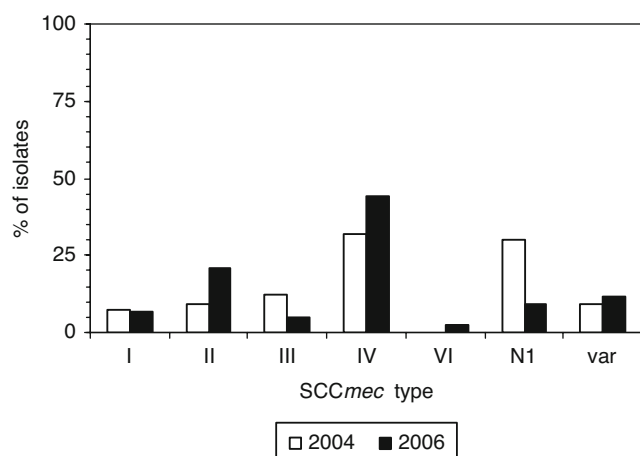
gave no amplification products from SCCmec typing PCR. The remaining strain amplified a single band containing the *dcs* region present in SCCmec types I, II, and IV, but appeared to have lost the region(s) that may have encoded other SCCmec typing loci, including the *mecA* gene. Pulsed-field gel electrophoresis (PFGE) analysis of these 12 strains identified ten distinct SmaI restriction profiles (Supplementary Fig. 1), indicating that the majority of the isolates were not closely related and hence loss of *mecA* was not associated with a specific clonal background(s). Susceptibility profiles of these strains also showed that there was no clear relationship between these strains (Supplementary Table 1). These strains were subsequently removed from the study. The remaining 99 isolates included 56 from 2004 and 43 from 2006 (Table 1).

### SCCmec type I

The smallest group, containing only seven isolates, was composed of SCCmec type I MRSA and remained stable over the observed period (7.1% in 2004; 6.9% in 2006) (Fig. 1). Five of these isolates were highly oxacillin resistant, with MICs >256 μg/ml, and were resistant to ciprofloxacin, gentamicin, clindamycin, and erythromycin. The remaining two strains carried only fusidic acid and erythromycin resistances, were heterogeneously oxacillin resistant, with MICs of 12 μg/ml, and contained the *tst* gene. One isolate from 2004 (ZH159) had a SCCmec type I multiplex PCR profile, but contained a *ccrAB2* complex and was therefore grouped among the variants.

### SCCmec type II

A total of 14 isolates had typical SCCmec type II profiles, containing the *ccrAB2* complex. This group strongly increased from 2004 (8.9%) to 2006 (20.9%) (Fig. 1). Generally, they had high oxacillin MICs and were resistant to ciprofloxacin and erythromycin. Five other isolates amplified multiplex PCR profiles identical or similar to that of type II, but were classified as containing variant SCCmecs on the basis of *ccr* typing. Two of these contained only *ccrAB1* and were considerably more multi-resistant than the normal SCCmec type II isolates, and one contained the *tst* gene. The other three had multiple *ccr* complexes: ZH299 contained both *ccrAB2* and *ccrAB1*, was PCR-positive for *pvl*, and had no additional antibiotic resistances; ZH293 had *ccrAB2* as well as *ccrAB4* and carried *tst*; the third strain (ZH152) contained both *ccrAB1* and *ccrAB4*.



**Fig. 1** Percentage of SCCmec types from isolates collected during 2004 and 2006



### SCCmec type III

SCCmec type III is a composite element containing both *ccrAB3* and *ccrC* complexes. Only a small proportion of isolates contained SCCmec type III, which further declined from 2004 (12.5%) to 2006 (4.6%) (Fig. 1). SCCmec-type III MRSA were by far the most multiresistant, with resistances to at least six of the nine antibiotic classes tested. Two isolates had SCCmec type III-like multiplex PCR profiles, except that one from 2004 (ZH143) lacked the SCCmec type III J3-specific band and another from 2006 (ZH269) lacked the SCCmec type III J1-specific band. Both isolates amplified only *ccrC* and one was a carrier of *pvl*. Unlike the classical SCCmec type III isolates, which had an oxacillin MIC >256 µg/ml, these two were low-level resistant strains with oxacillin MICs of 3 and 6 µg/ml, respectively. These two isolates were also much less multiresistant and have therefore been grouped among those carrying variant SCCmecs.

### SCCmec type IV

The largest proportion of MRSA isolates contained SCCmec type IV, with 18 isolates in 2004 (32%) and 19 in 2006 (44%) (Fig. 1). The oxacillin MICs in this group of strains ranged from 1 to over 256 µg/ml. Eight out of the 37 type IV MRSA were *pvl* positive. Two of these isolates also carried an ACME and were closely related to strain USA300 as they had the same SmaI PFGE pattern. A third type IV SCCmec strain with a different PFGE pattern also carried ACME, but was *pvl* negative. Type IV MRSA generally had few additional resistances to other antibiotics. The most common resistances found, in decreasing order, were erythromycin in 22 (59.4%), tetracycline in 11 (29.7%), ciprofloxacin in 14 (37.8%), and fusidic acid in five (13.5%) strains. Three additional strains had SCCmec type IV multiplex PCR profiles, but were segregated from this group due to their *ccr* type. One isolate (ZH273) appeared to contain SCCmec type VI on the basis of amplifying a *ccrAB4* complex in addition to the *mecA* and *dcs* bands, common to both types IV and VI [16]. This strain was significantly more multiresistant than SCCmec type IV strains. Another isolate (ZH305) contained both *ccrAB2* and *ccrAB4* and was resistant to four of the ten antibiotics tested. The third (ZH298) contained a *ccrAB1* complex, had an exceptionally low oxacillin MIC of 0.38 µg/ml, and its only additional resistance was to fusidic acid. Both ZH305 and ZH298 were grouped with the variant SCCmec types.

### Drug clones

Twenty one isolates that amplified only the *mecA* band by SCCmec typing were confirmed by drug clone specific

*ccrAB* PCR [7] to carry the drug clone SCCmec and were shown to produce the characteristic SmaI pattern of the original type clone CH482 by PFGE [7, 20], which belongs to ST45 and has the *spa* type t065. All drug clones were also trimethoprim and fusidic acid resistant. All except six were ciprofloxacin resistant. Their oxacillin resistance levels were low, between 1.5 and 6 µg/ml, and none had acquired additional resistances, suggesting that the drug clone maintained all its characteristics and showed no further evolution to multiresistance or higher oxacillin resistance. The number of drug clone MRSA isolates detected was drastically reduced from 17 isolates in 2004 (30.3%) to only four in 2006 (9.3%) (Fig. 1).

### Conclusion

The University Hospital of Zurich has a very low prevalence of MRSA compared to many other worldwide healthcare facilities. Periodic surveillance of MRSA, based on SCCmec and *ccr* typing, was performed to follow the evolution of MRSA diversity between 2003 and 2006. During this period, numbers of MRSA carrying typical hospital acquired SCCmec type I, II, and III elements appeared to have remained relatively stable (28.5% in 2004 versus 32.4% in 2006). However, large fluctuations within this group included an increase of more than twofold in SCCmec type II isolates and a drastic reduction of type III isolates. SCCmec type IV-containing isolates have remained the most prevalent, making up 32.1% and 44.2% of all isolates in 2004 and 2006, respectively. The drug clone, which was very prominent in 2003, seems to be on the decline and does not seem to have acquired any additional resistances, nor spread into the hospital. As a long-term consequence of the disruption of the drug scene in 1995, the locally restricted drug clone is dying out, or has possibly moved to other locations that are not in the catchment area of the University Hospital. The frequency of drug addicts hospitalized at the University Hospital has also declined in recent years.

Ten strains appeared to contain variant SCCmec types. Many of these were similar to defined SCCmecs but appeared to have undergone deletions, rearrangements, or recombinations, leading to losses of *ccr* loci or to the accumulation of multiple *ccr*'s. Generally, strains carrying these variant SCCmecs were also divergent in their resistance patterns, oxacillin MIC, and bearing mobile virulence factors such as *pvl*, *tst*, or *arcA*, compared to the corresponding SCCmec type they were most similar to. The observation that almost 10% of the analysed MRSA have undergone SCCmec rearrangements suggests that this chromosomal region is very active. PFGE analysis showed significant genetic diversity amongst the isolates with

variant SCCmec profiles (Supplementary Fig. 2), indicating that the recombination events leading to the evolution of new SCCmec structures had not occurred exclusively or preferentially in any specific clonal background.

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